IPRS Implementation Steering Committee

Meeting Minutes - November 28, 2001

Attendees:

IPRS Implementation Steering Committee

Karen Andrews, Pathways
Diane Poe, Center Point
Barbara Moore, Tideland
Vince Joyce, Mecklenburg
Bob Stayton, Sandhills
Gary Imes, DMH/DD/SA

IPRS Implementation Support and guests

Christal Wood, Duplin-Sampson-Lenoir
Ken Jones, Duplin-Sampson-Lenoir
Tommy Scott, Sandhills
Tom McDevitt, Smoky
George Scott, Blue Ridge
Karen Sticklin, DD Section
Rick DeBell, DMH/DD/SA
Carol Duncan Clayton, NCCCP
Jack Chappell, Controller's Office
Bob Duke, Controller's Office
Bleecker Cooke, DIRM

Division Implementation Team

Mark Robeson, Lee-Harnett
Art Eccleston, DMH/DD/SA
Betty Cogswell, DMH/DD/SA
Jim Ryals, DIRM
Cheryl McQueen, DIRM
Rick Olson, DIRM

1) Introductions / Announcements

On November 6, 2001 Gary Imes received IRMC certification to finalize the DHHS (IPRS) 30-month Fiscal Agency contract with EDS. The contract will provide fiscal agency services to the pilot area programs and to all other area programs when they migrate to IPRS. It will also provide funds to enhance IPRS and to change IPRS to remain consistent with evolving HIPAA requirements.

Gary Imes mentioned he will return to the IRMC in April 2002 to give a final report on the completed development phase and to present a detailed plan for the Statewide implementation of IPRS. All report materials need to be submitted to the IRMC QA group by March 15, 2002.

2) Review and approve minutes

The Committee accepted the October 17 minutes, which now will be posted to the web.

3) Development Project Status

The pilot Area Programs completed the three cycles of Stage two integration testing and are on schedule to run two cycles of production testing December 5 - 21. The team anticipates the testing will be successful and will complete the remaining tasks to wrap-up the project by December 31. The pilots will officially be operating IPRS in production as of January 1, 2002. The Development Steering Committee plans to meet on January 4, 2002 to formally accept the system.

4) The State Plan

Art Eccleston said a slightly revised version of the plan would be submitted to the Legislative Oversight Committee on November 30. There were no significant changes in the revision, most were style changes. The target population groups remain mostly unchanged, although a group for "co-occurring" diagnosis was added. Gary mentioned that by February 2002, population groups will need to be finalized to provide time for the pilot area programs to re-enroll clients where necessary and be prepared for processing by July 1, 2002. Covered

services will not be stated in the State Plan as such, but when available, will be appended to the document.

During the discussion related to the State Plan the following questions and/or observations were made:

A) Do the pilot Area Programs have cross-area service providers? DS and SEC do not.

B) How will Administrative Overhead expenses be reported and processed? There was not a clear answer to this, but this must be clarified well in advance of July 1, 2002.

C) Budget rules need to be available by January 2003 to ensure Area Programs can prepare an appropriate budget that must be in place for July 2003. Question: Should this concern be stated within the Division and Area Programs' annual MOA?

D) It is important that Fiduciary agreements for Area Programs (LMEs) be defined with sufficient lead-time for Area Programs to process/finalize.

E) Hold harmless - Gary indicated that presently the period of Hold harmless (no position available at this time) would apply only to the fiscal year of July 1, 2002 to June 30, 2003.

F) Service code modifiers were raised as a concern. Suggested this topic be on the agenda for the December MIS meeting.

G) Concern was again expressed that the implementation timeframe was too limited to permit an Area Program to merge with another Area Program, and then to migrate to IPRS.

H) Some Area Programs may encounter processing bottlenecks with their current system configurations in attempting to handle the volume of IPRS client and claim activity (Add to implementation phase selection criteria).

5) IPRS Implementation Plan

Betty Cogswell reviewed the status of work being done on the initial groupings of Area Programs into one of four implementation phases. She said she would soon distribute the following information to IPRS coordinators and the Area Program Directors:

- A sample MOA defining the responsibilities of the Division, Area Program and Software Vendor to migrate to IPRS within the specified implementation phase.
- Training plan for Area Programs to learn how to develop specifications for creating 834 and 837 transmissions and to receive an 835 transmission. This training would prepare the Area Program staff to quickly and successfully complete the required work with a minimum of problems.
- A presentation to Area Program Directors, Finance officers and IPRS Coordinators on Lessons Learned (by the pilot Area Programs) and on techniques that will help them plan and organize the work they must accomplish to migrate to IPRS.

Other points noted:

A) Betty asked that each Area Program provide their first and second choices of a preferred implementation phase to move to IPRS. She plans to complete and distribute the first draft of Area Program assignments to each phase by January 31, 2002. By March 1, the first group would start working on their initial implementation tasks.

B) Karen Andrews said it would be very helpful if the Division could provide Area Programs with additional criteria they could use themselves to evaluate which phase would be best to pick.

C) The group asked the Division to provide information about the new population groups to the Area Programs so that the clinicians could start assessing their clients to determine how they should be assigned.

D) Christal K. Wood suggested it may be helpful to find and refine the original check sheet used by Tim Wildfire to identify Area Programs that were good candidates to be pilots in the development phase of the project. The group agreed that this should be done.

E) The group felt strongly that there would be great value in training clinicians in how IPRS functions and to clarify the role clinicians will have in successfully migrating to IPRS.

F) Christal K. Wood volunteered to provide DS's matrix for the decision making process the Area Program uses to fit clients into population groups, benefits and covered services. Everyone agreed this would be very helpful.

G) Regarding the documentation of the existing population groups - Cheryl plans to complete the reformatting of the documentation by November 30. Betty will prepare it for publication and have it moved to the IPRS web site by December 14.

H)

Carol D. Clayton inquired if a service order was needed to enter data for IPRS?

A discussion ensued that medical records documentation requirements would not be driven by IPRS, i.e. if a service order was not required before, it would not be required under IPRS.

However, for example, given that a service like case support will now be billed as a unit of service, the question arose as to what kind of audit trail might then be used to verify the service itself. This example suggests there are policy implications that need to be considered prior to implementation. It was suggested the issue be communicated to Tara Larson in writing for response.

I) A topic for the Internal Workgroup's Agenda -
The issue of the interface between the eligibility/benefit plans from a technical standpoint and the integration of that with the clinical standpoint.

Specifically, the state plan targets specific populations for services, but then defines a full array of services. Without a utilization management overlay and a software system/ claims payment system that supports claims payment or denial from an "authorization" standpoint, the LME will not be able to manage state dollars to ensure there are monies available throughout the year for all high priority, targeted individuals. The claims payment system must be able to support the UM system.

For example, (in Carol Clayton's private experience) it was possible to enter in an authorization for a service type, a limit on either visits/time period, and an end date. The claims system could deny a claim for lack of eligibility and lack of authorization based on all of these variables so the money was managed within the system.

The state has not yet moved to define what the "utilization management" of these services across populations will look like (for non-Medicaid) and it is important not to lose sight that LME's must have IPRS support for whatever that definition is.

J) Tom McDevitt asked if the Division could provide an Area Program with assistance in evaluating the readiness of their hardware/software configuration (including networking) for IPRS. Gary Imes said that Hampton Carmine could be contacted at 919-733-7260.

6) IPRS Implementation Funding

Gary Imes mentioned the Division is exploring possibilities of assisting Area Programs migrate to IPRS (nothing has been identified at this point).

7) IPRS Communications and Training

Betty is presently organizing a presentation and work session for Area Programs to explore the 834, 837 and 835 transactions in detail and to review approaches Area Programs could use to proceed with their vendors to build these transactions. Tentatively scheduled for February 2002.

8) Escalation of Policy Issues

9) Action items - (highlighted in the material above)

Next Meeting Date and Location

January 16, 2001, 1- 3pm, NC Council - 1318 Dale St., Suite 120

(The December meeting was canceled)